

## REQUEST FOR PRIOR AUTHORIZATION FOR A NON-PREFERRED DRUG

**Please FAX or Mail To: RI PA CALL Center**  
**PO Box 25719, Richmond VA**  
**23286-8212**  
**Fax # 1-800-390-0109**

Date \_\_\_\_\_

Beneficiary Name \_\_\_\_\_ DOB \_\_\_\_\_ Medicaid ID Number \_\_\_\_\_

Prescriber Name \_\_\_\_\_ Prescriber NPI # \_\_\_\_\_ DEA# \_\_\_\_\_

Prescriber Office Address \_\_\_\_\_

Office Phone Number \_\_\_\_\_

Requester Name \_\_\_\_\_ RN/MD/RPH

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Drug Requested \_\_\_\_\_ QTY / FILL \_\_\_\_\_

Diagnosis, ICD-9 CODE\_\_\_\_\_

PDL Medications that the patient has tried \_\_\_\_\_

What was the outcome? \_\_\_\_\_

If you are requesting a brand name drug, provide the dates that the generic was tried and the outcome

Explain why this particular non PDL medication is medically needed for this beneficiary

**PRESCRIBER SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

**RI PRIOR AUTHORIZATION CALL CENTER PHONE NUMBER 1-866-420-3874, HOURS M-F, 9 AM-6 PM (EST)**

PA # \_\_\_\_\_ APPROVED \_\_\_\_\_ DENIED \_\_\_\_\_ PENDING ADDITIONAL INFORMATION \_\_\_\_\_

DATE /TIME OF RECEIPT \_\_\_\_\_ DATE/TIME RESPONSE \_\_\_\_\_ REVIEWER \_\_\_\_\_

COMMENTS: